

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BUREAU OF HEALTH SYSTEMS (BHS)

INFORMAL DEFICIENCY RESOLUTION REQUEST – LEVEL 2

Send this form (typed/printed) with documentation to: MDCH, BHS, Operations, Enforcement Unit, IDR Requests
P.O. Box 30664, Lansing, MI 48909.

The PoC should be submitted to the Licensing Officer that signed the Statement of Deficiencies (CMS-2567L).

This IDR is to be reviewed by: **BHS** **or** **MPRO** (Facility agrees to pay fee for service.)

Facility:

Survey Exit Date:

1. Tag No(s):

2. Citation fact(s)/statement(s) requested for review:

3. Factual evidence that you believe refutes the above fact(s)/statement(s):

(attached pages should be numbered; for example, 1 of 20, 2 of 20, etc.)

4. Explain if the above evidence was not available at time of survey:

Facility Contact Person:

Date:

Phone:

REVIEWER RESPONSE – LEVEL 2

Deficiency is: (check one)

Supported in full ☐

Amended ☐

Deleted ☐

Reason:

Reviewer's Signature:

Date:

Title:

Code/s: **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** **11**